

[illegible]

Determinations of Non-Reviewability exemption requests must be submitted with a fee in accordance with WAC 246-310-990 and the completed invoice on page 2 of this form.

Name of the Ambulatory Surgical Center

PRINT Name of person making the request

Telephone Number

Title of person making the request

Relationship to the Ambulatory Surgical Center

I understand that any evasion or suppression of material facts, misrepresentation, false statements or misleading statements regarding any of the information contained in this application may invalidate the department's Determination of Non-Reviewability that was based on that material.

Signature of Applicant

Date _____

Address:

Invoice for Submission of Ambulatory Surgical Center Determination of Non-Reviewability

1. This form must be accompanied by a check payable to: ***The Department of Health*** for the review fee as identified below.
2. Complete the following prior to submission for review:

REVIEW FEE: \$1,261

APPLICANT NAME: _____

DATE OF SUBMISSION: _____ CHECK NUMBER: _____

4. Mail **ORIGINAL** and payment to:

**Department of Health
Certificate of Need Program
M.S. 47852
Olympia, Washington 98504-7852**

WASHINGTON STATE CERTIFICATE OF NEED PROGRAM
RCW 70.38 AND WAC 246-310

Determination of Non-Reviewability-Ambulatory Surgical Centers (ASC)

Please note the following definition:

"Ambulatory surgical facility" means any freestanding entity, including an ambulatory surgery center that operates primarily for the purpose of performing surgical procedures to treat patients not requiring hospitalization. This term does not include a facility in the offices of private physicians or dentists, whether for individual or group practice, if the privilege of using such facility is not extended to physicians or dentists outside the individual or group practice.

This term also includes an ASC that is licensed under a hospital's license but located outside of the hospital's main facility.

1. Address of your clinical practice. If you have more than one practice site, please list all sites. Attach additional pages as necessary.

2. Please describe the services provided at each practice site. Attach additional pages as necessary.

3. Is your clinical practice a solo practice? ☐ group practice? ☐ IPA? ☐ or other? ☐

4. If you checked "Other" from question 3, please describe the organizational structure of clinical practice.

5. Does any other party or parties have an ownership in the clinical practice? Yes_____ No_____

6. If yes to question 5, please identify the party or parties that have an ownership in the clinical practice and their respective ownership percentage(s).

7. If you checked "group practice" from question 3, please provide a copy of the group practice agreement.

8. List **all** the physicians proposed to use the ASC and indicate whether they are a member/partner of the group clinical practice, employed by the clinical practice, or other. If other, describe the arrangement. Attach additional pages as necessary.

Name of Physician	Member/Partner	Employed by practice	Other

9. For each physician identified in question 8 as being employed by the clinical practice, please provide the following information:

Name of Physician	Percent of Time Employed by Applicant's Practice (i.e. 25%, 50%, 100%)	Name of any other practice the physician is employed by	Percent of Time the Physician is employed by the other practice(s)

10. Do **any** of the physicians listed in question 8 have other practice sites not included in questions 1 or 8?
Yes _____ No _____

11. If the answer to question 10 is **yes**, please list those sites and describe the services provided at each of those sites. Attach additional pages as necessary.

Name of Physician	Other Practice Site(s)	Percent of Time the Physician conducts business at the other practice site(s)	Description of Services Provided At Other Practice Site(s)

12. Address of the proposed ASC:

13. Describe the location of the proposed ASC in comparison to the location of the clinical practice. (i.e., in the same building, in a separate building, within the office suites of the clinical practice).

14. Will the ASC be a separate legal entity from the clinical practice? Yes_____ No _____

15. If **yes** to question 14, identify the legal structure of the ASC. Attach additional pages as necessary.

16 Will the proposed ASC be operated under a management agreement? Yes _____ No _____

17. If the answer to question 16 is **yes**, provide a copy of the management agreement (either executed or draft).

18. Please identify the procedures to be performed at the ASC?

19. Will a facility fee be charge for each procedure? Yes_____ No_____ Combination_____

20. If the answer to 19 was a combination, please identify which procedures will be charged a facility fee.

21. Will any other party or parties have an ownership in the ASC? Yes_____ No_____

22. If yes to question 21, please identify the party or parties that will have an ownership in the ASC and their respective ownership percentage(s).

23. Is any other ASC(s) also using the proposed ASC space (i.e. timeshare arrangement) Yes _____ No_____

24. If yes to question 23, Please identify the other ASC or ASCs that will be a party to the timeshare agreement.

25. Please provide a copy the timeshare agreement. (A draft is acceptable, however, if the Department determines the ASC as proposed is exempt, an executed copy of the timeshare agreement must be provided to the Department prior to commencing operation of the ASC.) Please note, any timeshare agreement must include the day(s) and time(s) each ASC identified in question 24, has or will have exclusive use of the ASC.